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The Urgent Need for Sexual and Reproductive Health Care Services for Human Trafficking Survivors in the United States

Distinguished Members of Congress and Staff:

Thank you for allowing me to submit this testimony regarding the sexual and reproductive health needs of survivors of human trafficking. Since 2005, I have had the privilege of working as a volunteer physician for survivors of human trafficking in Los Angeles, California. In this capacity, I provide primary care as well as sexual and reproductive health care during 2-3 clinical sessions each month. Over the last six years, I have also conducted research with survivors of trafficking in Los Angeles in order to better understand the health effects of trafficking and to explore the potential for victim identification in health care settings. I have shared my clinical expertise and research findings with audiences at professional meetings, conferences, and trainings in Southern California and other regions of the U.S., and more recently through publication of a peer-reviewed article.

The work I have done with human trafficking survivors has been in partnership with nongovernmental organizations (NGOs) in Los Angeles who provide direct client services. My clinical work with trafficking survivors has also depended upon support from community clinics in the safety net system of Los Angeles County; the trafficking survivors' clinic was based at the Venice Family Clinic from 2005 – 2007 and has been housed at the Saban Free Clinic, formerly known as the Los Angeles Free Clinic, since November 2007. I also have provided care to survivors at the UCLA Reproductive Health Services clinic, when I was affiliated there through 2008. These partnerships have been especially critical in providing access to care for the foreign national human trafficking survivors I have primarily served, as these survivors have limited access to other venues for medical care because of their immigration status and lack of health insurance coverage.

My employer, the Los Angeles County Department of Public Health, has provided me the support and flexibility to continue this volunteer clinical work since I joined the Office of Health Assessment and Epidemiology in 2006. However, the views I express in this testimony are mine alone and do not represent those of the Los Angeles County Board of Supervisors or the Los Angeles County Department of Public Health.

As for my medical background, I am board certified in General Preventive Medicine and Public Health, and am a Fellow of the American College of Preventive Medicine. I graduated from Columbia University with an AB in biology, attended the State University of New York Downstate College of Medicine, completed an internship in obstetrics and gynecology at the University of Arizona Medical Center, and residency at the same institution in Preventive Medicine and Public Health, during which I earned a Master's in Public Health. I completed two research fellowships, one in Cancer Prevention and Control at the University of Arizona Cancer Center, focused on cervical cancer prevention, and one in women's health services research at the Greater Los Angeles Veterans Administration and UCLA. My professional positions have included serving as Medical Director for Planned Parenthood of Southern Arizona; Assistant Clinical Professor of Obstetrics and Gynecology at the University of Arizona College of Medicine; contract physician at the Chiricahua Community Health Center in Douglas, Arizona; consulting Medical Director of Clinical and Community Programs at the California Family Health Council;

and contract provider at Planned Parenthood of Orange and San Bernardino Counties. I have authored or co-authored 16 articles in the peer-reviewed medical literature, covering women's health and public health topics, as well as 4 book chapters. Earlier this year, I was honored with the Los Angeles County Department of Public Health's Physician Leadership Award for Health Equity, and also with the Freedom Network's Paul and Sheila Wellstone Award for my contribution and dedication to anti-trafficking efforts in the United States.

In my experience working as a medical provider for victims of human trafficking, I have learned first-hand that they typically experience dangerous and degrading conditions that impact their physical and mental health, both in the short and long term. Upon initiating health care, survivors of human trafficking often present with many complaints and symptoms, reflecting a variety of health issues. To progress in their recovery from trauma and to achieve healthy, productive lives, survivors of human trafficking require access to a broad range of health-related services, including sexual and reproductive health care.

As an example, allow me to share with you the story of Grace, a survivor or labor trafficking. Grace, a petite woman in her late 20's, routinely experienced physical and emotional abuse by the family that kept her as a domestic servant, first in the Middle East and then in the United States. Grace, a survivor of female genital mutilation, was also raped by the man of the household. Grace came to her first few appointments with me with an interpreter, and talked so quietly she could barely be heard. Aside from experiencing stomach pain, vomiting blood, and having nearly daily headaches, Grace complained of severe pelvic pain. I treated her for a pelvic infection, and then she underwent treatment for high grade cervical dysplasia, or pre-cancer, following a highly abnormal pap smear—which was the first pap smear she had ever had. After these treatments, Grace's pelvic pain persisted for many months, but we were eventually able to decrease it with the use of hormonal contraceptives. With her pelvic pain diminished, and her stomach issues and head pain controlled with medication, Grace was able to attend school, become a certified nursing assistant, get a job, and eventually learn to drive, which greatly increased her options for a productive life in Los Angeles.

My experiences working directly with trafficking survivors reflect the findings of research in this field. Trafficking survivors' need for sexual and reproductive health care is recognized by experts internationally. In 2001, Raymond and Hughes, in a report for the Coalition Against Trafficking in Women, noted that

> "A significant number of women who have been trafficked and prostituted suffer multiple health effects from violence and sexual exploitation. Women in the sex industry sustain the same kinds of injuries as women who are battered, raped and sexually assaulted."

Reproductive health problems observed by these authors among victims of trafficking in the United States included vaginal bleeding, sexually transmitted infections, urinary tract infections, and unintended and forced pregnancy. [1]

In reports released in 2003 and 2006 by Cathy Zimmerman and colleagues at the London School of Hygiene and Tropical Medicine and a network of European NGOs, researchers described in detail the sexual and reproductive health effects of sex trafficking.[2,3] Survivors in these studies reported the frequent experience of rape and sexual assault during trafficking. They reported inconsistent use of condoms, lack of awareness of other forms of contraception, frequent douching (which increases risk for sexually transmitted infections), unintended pregnancy, sexually transmitted infections, and concerns about fertility. Several studies have reported on the very high risk for HIV and other sexually transmitted infections in women trafficked in South Asia.[4,5,6,7] In another study of European trafficking survivors by Zimmerman, et al, published in the American Journal of Public Health in 2008, 63% of the women reported 10 or more concurrent physical health symptoms when evaluated during their first 2 weeks of post-trafficking services.[8] These symptoms included not only general health symptoms like fatigue, dizziness, headaches, and stomach pain, but numerous reproductive health symptoms including vaginal discharge, gynecologic infection, pelvic pain, pain with urination, and vaginal bleeding unrelated to the menstrual cycle.

While most of the published research focuses on survivors of sex trafficking, my clinical and research experience suggest that that labor trafficking survivors experience similar symptoms and health complaints post-trafficking. For example, in the small study I conducted among women trafficked to Los Angeles, most of whom were victims of labor trafficking, 43% reported having experienced gynecologic or "female" problems. While not all of these problems were necessarily caused by trafficking, they underscore the clear need for comprehensive sexual and reproductive health care among this population.

In recognition of the sexual and reproductive health needs of all human trafficking survivors, the International Organization for Migration/ UN Global Institute to Fight Trafficking/ London School of Hygiene and Tropical Medicine handbook, issued in 2009, titled "Caring for Trafficked Persons: Guidance for Health Providers," states:

> "Many people are trafficked for purposes of sexual exploitation; trafficked persons in other types of exploitation may also be sexually abused as a form of coercion and control. As a consequence, trafficked persons, regardless of gender or age, are at risk of developing complications relating to sexual and reproductive health. Addressing sexual and reproductive health issues is therefore an important component of caring for someone who has been trafficked. It is essential that every trafficked person receive timely, competent and comprehensive sexual and reproductive health services even if they were not trafficked explicitly for sexual exploitation."[9]

Having worked with this victim population in Los Angeles for over six years, my own experience confirms that sexual and reproductive health services are essential components of the health

care requested and needed by survivors of both labor and sex trafficking. Necessary services include testing and treatment for sexually transmitted infections; education and counseling about condom use, fertility, and methods of contraception; provision of condoms and contraception, including emergency contraception; and preconception counseling to optimize maternal health prior to pregnancy. In the case of unwanted pregnancy, trafficking survivors require medically accurate, unbiased options counseling that informs women of their right to access prenatal care, adoption services, and safe, legal abortion, and they require access to abortion services themselves. For survivors of trafficking with intended or wanted pregnancies, access to prenatal care, labor and delivery services, and post partum care are also essential, as is connecting the new mother with family medicine or pediatric services for her newborn.

In my practice with trafficking survivors, I have had the opportunity to provide, or to provide referrals for, all of these types of care. For the purpose of this testimony, I will emphasize the contraception and abortion care needs of my female patients, given that these are specific services that the United States Conference of Catholic Bishops (USCCB) excluded from coverage with the federal funds it disseminated to support trafficking survivors through the agencies it contracted with across the United States.

Contraception

For women of reproductive age, contraception is a fundamental part of medical care. The average American woman who wants to bear 2 children will use contraception for approximately 3 decades.[10] Unintended pregnancy is associated with numerous potential negative health outcomes for women and their children, partially resulting from delayed pre-natal care and parental behaviors during and after pregnancy.[11] Importantly, studies have demonstrated the importance of birth spacing on reducing low birth weight and pre-term delivery.[12] An expanding body of literature supports the optimization of maternal health, including mental health, prior to conception in order to improve both maternal and child health outcomes.[13]

For survivors of human trafficking, preventing and planning pregnancy is potentially even more important than it is for the average American woman, due to the physical and mental health issues many survivors cope with as they initiate their recovery from trafficking. However, many survivors of trafficking, particularly international survivors, lack education about the menstrual cycle and reproductive physiology, and have no awareness of the most effective ways to use natural or traditional family planning such as the rhythm method, much less awareness of the availability of safe, modern methods of contraception. To be able to achieve reproductive health, trafficking survivors of reproductive age need access to comprehensive contraceptive counseling and provision by a culturally sensitive, trained provider.

I am fortunate to practice medicine in California, a state that has the best publicly funded family planning program in the nation. I am able to provide all of my patients, regardless of their immigration status or their lack of income, whichever form of FDA - approved contraception is best for their health and lifestyle. However, *in many jurisdictions through the United States, the*

only access survivors have to comprehensive family planning services may come from funds provided through the Department of Health and Human Services for trafficking survivors' health care. This may be the case especially for survivors who would like to use some of the more effective methods of long acting reversible contraception, such as implants and intrauterine contraceptives, which save women and society money in the long-term, but are very expensive initially.

Education about condoms is another important component of the reproductive health care needed by survivors. While a discussion about condoms is part of comprehensive contraceptive counseling, the role of condoms in preventing sexually transmitted infections deserves independent emphasis among both male and female survivors, some of whom are at higher risk for infection than the general population.

An additional essential component of reproductive health care for trafficking survivors is access to emergency contraception. Emergency contraception, most commonly delivered in the form of a pill, is a time-sensitive intervention that can prevent pregnancy after sex, primarily by inhibiting ovulation. To be effective, emergency contraception must be administered within 72 – 120 hours after sexual intercourse.[14,15] Survivors of trafficking newly escaped or rescued from their situation, whether a labor or sex trafficking situation, should be offered this treatment in order to reduce their risk for unintended pregnancy. As with survivors of rape who present to a hospital emergency room, offering emergency contraception should be a routine step in the initial care of survivors of human trafficking.

Since many women born and raised in the United States do not know about emergency contraception or how to access and use it, we can assume that knowledge of this method is low among victims trafficked from abroad. It is therefore incumbent upon the case managers and other service providers assisting these women to *provide their clients immediate education* about this option, or access to someone who can provide the education. In addition, the agencies assisting survivors will likely need to pay for the treatment in order for women to be able to utilize it. While a very effective form of emergency contraception is available from pharmacists without a prescription for anyone 17 years of age or older, it can be priced at $50 or more, a cost prohibitive to most trafficking survivors, and undoubtedly out of reach for the many who escape from trafficking with nothing but the clothes on their backs.

Abortion

In the report, "The health risks and consequences of trafficking in women and adolescents: findings from a European study," the authors discuss use of abortion services by trafficking victims, noting that 5 out of 6 women who experienced an unintended pregnancy while they were trafficked terminated the pregnancy. They add,

> "The preference for termination of unintended pregnancy was reiterated by respondents who had never been pregnant, the majority of whom stated that they would have sought an abortion had they become pregnant in the destination country. However, awareness of TOP [termination of pregnancy] services was generally low. Only two out of twelve respondents who had never been pregnant were able to identify an accessible TOP provider in their destination country. Ignorance of abortion services, anti-abortion laws, and lack of free or affordable TOP services increase the likelihood that women will turn to illegal practitioners.
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> While the safety and professionalism of illegal TOP services depends on the context (for example, in some countries where abortion is illegal, there are numerous safe illegal options), in most contexts the risk of having an unsafe abortion, with its attendant complications, rises when services are illegal."[3]

To more fully demonstrate the need for survivors of human trafficking in the United States to be able to access abortion care, I will share with you the story of one of my patients who chose to terminate her pregnancy. Celia, a survivor of sex trafficking in her late teens, came out of her trafficking situation pregnant as a result of one of the many rapes she experienced. Celia explained to me that she was not a virgin before she came to the United States, but that she had "never experienced anything like this" and felt very humiliated and ashamed about the things she was forced to do by her traffickers. She sometimes cried when she was in a room with a customer, and she also tried to run away, things that frequently got her into more trouble—that is, beaten.

Law enforcement broke up this trafficking operation, and Celia, who suspected she was pregnant, was fortunately brought to an appointment with me shortly after her arrival to an NGO service provider. Despite the horrors she had experienced during her 3 months in an LA sex trafficking ring, she retained her quick smile and I was able to glimpse her bubbly personality even at our first meeting. Celia told me she was sometimes allowed to use condoms in her "work" in an area near downtown LA, but sometimes she was not, depending on the desires of the men who purchased her services and the mood of the women who oversaw the prostitution ring. Though her face fell when we confirmed that she was indeed pregnant, a conversation about her options quickly led to visible relief. Abortion is not legal in Celia's home country, and prior to the options counseling she received in our clinic, she had no knowledge of the safe, legal health care choices available to her in the United States. She availed herself of pregnancy termination services, which improved her ability to recover from the trauma she had experienced.

I only saw Celia one or two more times after her abortion. She was fearful on the streets of Los Angeles, as many survivors are, always wondering if she would run into people who had known her as a sex slave. She moved to another city as soon as she was able to, and I didn't hear from her again. Still, I have a sense of comfort when I remember her, knowing that because of the reproductive health care she received from me, Celia could begin a new life, in a new town, without bearing the burden of carrying a pregnancy resulting from brutal rape.

Celia's story is not unique. Many trafficking survivors throughout the United States, particularly those trafficked here from other countries, have no knowledge of the range of sexual and reproductive health services that are available to them. When it comes to the most personal, profound issues they may face, including pregnancy prevention and pregnancy options, these women rely upon their case managers for information about and access to doctors, health educators, counselors, and other service providers. For the USCCB's contracting agencies to have been denied funds for provision of these referrals and services was clearly a dangerous disservice to the survivors we all care so much about protecting.

Trafficking victims are denied their autonomy when they are forced to perform hard labor or commercial sexual acts in the United States, against their will, and under threat of harm to themselves and their families. They suffer greatly as a result of having all of their choices in life taken away. For those who are lucky enough to leave their situation and access assistance, it is our responsibility to provide them the comprehensive services they need to begin the difficult recovery from being enslaved in the United States. Given the types of abuse human trafficking victims face, often for years at a time, these services must include access to the full range of sexual and reproductive health care, and information about the availability of these services.

As 2011 draws to a close, the Trafficking Victims Protection Reauthorization Act of 2011 has not yet been reauthorized. I hope that Congress will prioritize the reauthorization of this bill in the coming weeks. We need the TVPRA so that the United States can continue to lead the fight against human trafficking internationally, to ensure that justice is pursued and that vulnerable people around the world are prevented from experiencing the plight my patients have faced. We also desperately need the TVPRA in order to continue our fight against trafficking in the United States, to allow us to provide essential support and services to the victims we find here, in our own neighborhoods. Thank you for your consideration.

References

[1] Raymond JG and Hughes DM. Sex trafficking of women in the United States: International and domestic trends. Coalition Against Trafficking in Women, 2001. Available at: http://www.uri.edu/artsci/wms/hughes/sex_traff_us.pdf

[2] Zimmerman C, Yun K, Shvab I, Watts C, Trappolin L, Treppete M, Bimbi F, Adams B, Jiraporn S, Beci L, Albrecht M, Bindel J, Regan L. The health risks and consequences of trafficking in women and adolescents. Findings from a European Study. London: London School of Hygiene and Tropical Medicine, 2003.

[3] Zimmerman C, Hossain M, Yun K, Roche B, Morison L, Watts C. Stolen smiles: The physical and psychological health consequences of women and adolescents trafficked in Europe. London: London School of Hygiene & Tropical Medicine, 2006.

[4] Silverman JG, Decker MR, Gupta J, Dharmadhikari A, Seage GR 3rd, Raj A. S yphilis and hepatitis B Co-infection among HIV-infected, sex-trafficked women and girls, Nepal. Emerg Infect Dis. 2008;14:932-4.
[5] Dharmadhikari AS, Gupta J, Decker MR, Raj A, Silverman JG. Tuberculosis and HIV: a global menace exacerbated via sex trafficking. Int J Infect Dis 2009;13:543-6.
[6] Silverman JG, Decker MR, Gupta J, Maheshwari A, Willis BM, Raj A. HIV prevalence and predictors of infection in sex-trafficked Nepalese girls and women. JAMA 2007; 298(5):536-42.
[7] Gupta J, Raj A, Decker MR, Reed E, Silverman JG. HIV vulnerabilities of sex-trafficked Indian women and girls. Int J Gynaecol Obstet. 2009;107:30-4.
[8] Zimmerman C, Hossain M, Yun K, Gajdadziev V, Guzun N, Tchomorova M, et al. The health of trafficked women: a survey of women entering posttrafficking services in Europe. American Journal of Public Health 2008; 98:55-59.
[9] Caring for Trafficked Persons: A Guide for Health Providers. International Organization for Migration, UN GIFT, London School of Hygiene and Tropical Medicine. 2009.
[10] The Alan Guttmacher Institute, Fulfilling the Promise: Public Policy and U.S. Family Planning Clinics, New York: AGI, 2000.
[11] The Best Intentions: Unintended Pregnancy and the Well-Being of Children and Families. Institute of Medicine, 1995.
[12] Norton M. New evidence on birth spacing: promising findings for improving newborn, infant, child, and maternal health. ′ International Journal of Gynecology & Obstetrics 2005; 89:S1-S6.
[13] Johnson K, Posner SF, Biermann J, Cordero JF, Atrash HK, Parker CS, Boulet S, Curtis MG. Recommendations to Improve Preconception Health and Health Care --- United States. MMWR 2006; 55;1-23.
[14] Von Hertzen H, Piaggio G, Ding J, Chen J, Song S, Barfati G, et al. Low dose mifepristone and two regimens of levonorgestrel for emergency contraception: a WHO multicentre randomized trial. Lancet 2002;360:1803-10.
[15] Ellertson C, Evans M, Ferden S, Leadbetter C, Spears A, Johnstone K, Trussell J. Extending the time limit for starting the Yuzpe regimen of emergency contraception to 120 hours. Obstetrics & Gynecology 2002; 101:11168-71.